ARTMENT OF HEALTH AND HUMAN SERVICES
LTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 9 — 3 6

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1999

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 1998-1999 $ (46,459,400)
b. FFY 1999-2000 $ (92,918,800)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Part 1 Pages 110,112(d),112(f)(1), 117(a),117(c),118,120,137,145,146,148,148(b), 153(b),226(a)

**** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part 1 Pages 110,112(d), 112(f)(1),117(a),117(c),118,120,137,145,146, 148,148(b),153(b),226(a)

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

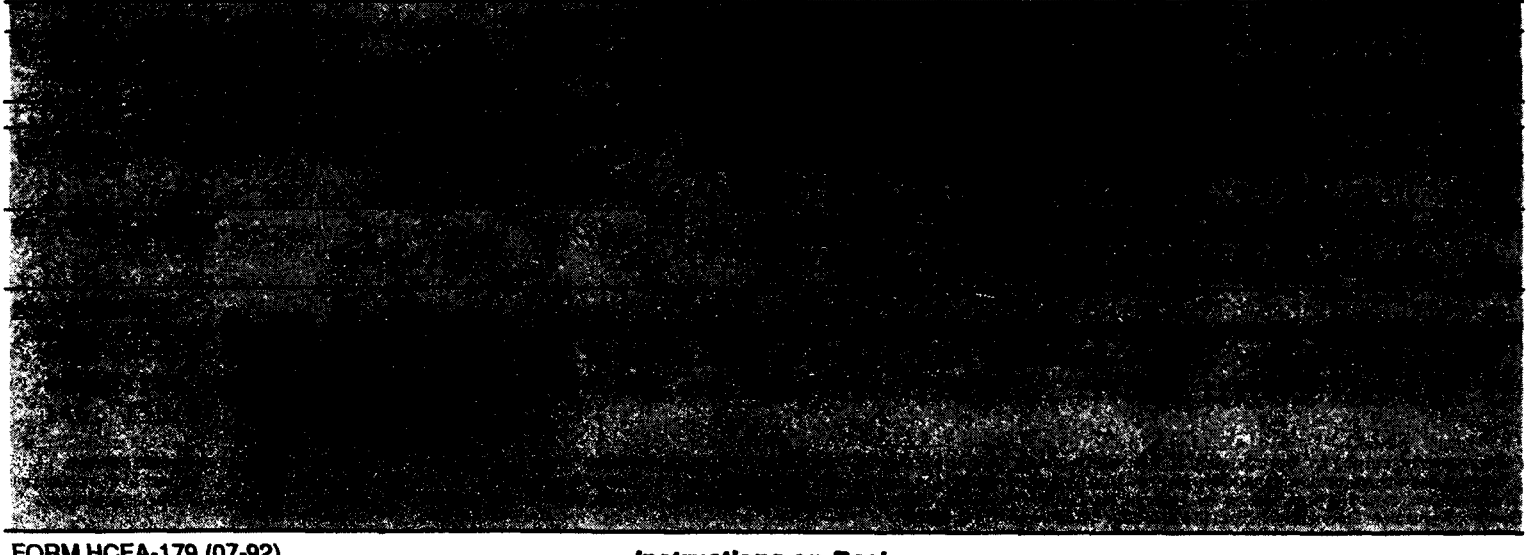
12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Antonia C. Novello, M.D., M.P.H.

14. TITLE:
Commissioner

15. DATE SUBMITTED:
September 30, 1999

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237



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Instructions on Back

(2) a factor of ¼ percent of a general hospital's trended reimbursable inpatient operating cost as defined in section 86-1.54 of this Subpart, shall be allocated to costs of general hospitals for technology advances, provided, however, this allocation shall not apply for the periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, 2000;

(3) a factor of ¼ percent of a general hospital's trended reimbursable inpatient operating cost as defined in section 86-1.54 of this Subpart shall be allocated to the costs of general hospitals for increased activities related to quality assurance and patient discharge planning; and

(4) the balance of the one hundred and thirty million dollars after deducting the dollar value of the allocation specified in subclauses (1), (2) and (3) above shall be allocated to costs of general hospitals based on the ratio of each general hospital's 1985 costs incurred in excess of the trend factor between 1981 and 1985 in the following discrete areas, summed, to the total sum of such cost over trend of all general hospitals applied to such balance: malpractice insurance costs, infectious and other waste disposal costs, water charges, direct medical education expenses, working capital interest costs of hospitals that qualified for distributions pursuant to section 86-1.36 of this Supart, costs of distinct psychiatric units excluded from the case based payment, and ambulance costs. For the purpose of this sub-

provided to beneficiaries of title XVIII of the Federal Social Security Act and excluding direct medical education costs.

(b) Effective January 1, 1991 through March 31, 1995 and effective on and after April 1, 1996, $33 million shall be allocated for technology advances and changes in medical practice. Amounts allocated to each general hospital shall be based on a fixed amount per bed determined by multiplying the number of certified inpatient beds for each general hospital as of June 30, 1990 by the result of dividing the $33 million by the sum of the certified inpatient beds for all general hospitals. Provided, however, this allocation shall not apply for the periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, 2000.

(c) $26 million shall be allocated to costs of general hospitals based on the costs incurred in excess of the trend factor between 1985 and 1989 in the following discrete areas: infectious and other waste disposal costs, universal precautions, working capital interest costs, costs for asbestos removal, costs of low osmolality contrast medic, malpractice costs, water and sewer charges, ambulance costs, service contracts, prosthetic and orthotic devices and costs related to designation as a trauma center and contracted nursing services.

(1) If the 1989 costs incurred in excess of the trend factor between 1985 and 1989 summed for each discrete area for all general hospitals is greater than or equal to $26 million, the $26 million shall be allocated to costs of general hospitals based on the ratio of each general hospital's 1989 costs incurred in excess of the trend factor in such discrete areas, summed, to the total sum of such cost over trend of all general hospitals.

(2) If the 1989 costs incurred in excess of the trend factor between 1985 and 1989 summed for all general hospitals is less than $26 million, the allocated costs to each general hospital

(DRGs) 475,483,540, 701-716 and 798-801.

(b) $63 million shall be allocated to general hospitals for labor adjustments. Such amount shall be allocated as follows:

(1) An amount equal to $55 million shall be allocated for labor cost increases incurred prior to June 30, 1993. Amounts allocated to each general hospital shall be based on the general hospital's share of the statewide total of inpatient and outpatient reimbursable operating costs based on 1990 data excluding costs related to inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54 (g) (3);

(2) An amount equal to $8 million shall be allocated for labor adjustments to general hospitals located in the counties of Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland, Columbia, Delaware and Westchester, to account for prior disproportionate increases in unreimbursed labor costs. Each general hospital determined pursuant to this subclause shall receive a portion of the $8 million equal to the general hospital's portion of the total inpatient and outpatient reimbursable operating costs based on 1990 data for all hospitals located in the counties identified pursuant to this subclause, excluding costs related to services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54(g)(3).

(c) $55 million shall be allocated for increased activities related to regulatory compliance universal precautions and infection control related to AIDS, tuberculosis, and other infectious diseases including the training of employees with regard to infection control, and for infectious and other waste disposal costs. A fixed amount per bed shall be allocated to the costs of each general hospital based on the total number of inpatient beds for which each hospital is certified as of August 24, 1993. Provided however, this allocation shall not apply for the periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, 2000.

(d) An amount equal to $3 million shall be allocated to the costs of each general hospital in the following manner and which meet the following criteria:

(1) $250 per bed shall be allocated to the costs of each general hospital having less than 201 certified acute care beds as of August 24, 1993 and classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by Federal law (see 42 U.S.C. section 1395 ww(d) (2) (D) or defined by Federal law (see 42 U.S.C. section 1395 ww(d) (2) (d) or defined as a rural hospital under section 700.2 (a) (21) of

(d) For rates of payment for discharges in 1991 and thereafter, a general hospital having less than 201 certified acute non-exempt inpatient beds that is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by federal law (see 42 U.S.C. section 1395 ww (d)(2)(D)) or defined as a rural hospital under state law may choose to have its DRG specific operating cost component be 100 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54 (a) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart, provided however, commencing April 1, 1996 through July 31, 1996 the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2), shall be reduced by five percent, and commencing August 1, 1996 through March 31, 1997 the reimbursable impatient operating cost component of case based rates of payment per diagnosis-related group, excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2), shall be reduced by two and five-tenths percent, and commencing April 1, 1997 through March 31, 1999 and July 1, 1999 through March 31, 2000, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54 (h)(2), shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. In order to exercise this option for 1991 or subsequent rate years, the general hospital shall notify the Department of such election in writing by no later than December first of the preceding rate year or a later date as determined by the Commissioner.

(e) As for discharges on or after April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, 2000, the DRG case-based rates of payment for patients assigned to one of the twenty most common diagnosis-related groups, will be held to the lower of the facility specific amount or the average amount, as determined pursuant to subdivision (c) of this section for all hospitals assigned to the same peer group. The twenty most common diagnosis-related groups shall be determined using discharge data two years prior to the rate year, but excluding beneficiaries of title XVIII (Medicare) of the federal social security act and patients assigned to diagnosis-related groups for human immunodeficiency virus (HIV) infection, acquired immune deficiency syndrome, alcohol/drug use or alcohol/drug induced organic mental disorders, and exempt unit of exempt hospital patients.

(f) Effective July 1, 1995 through June 30, 1996, rates of payment for inpatient acute care services shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law, regulation promulgated in accordance with applicable standards and procedures for promulgating hospital operating standards, the Commissioner, or other governmental agency as follows:

(i) An aggregate reduction shall be calculated for each hospital based upon: the result of eighty-nine million dollars annually for 1995 and trended to the rate year, multiplied by a ratio based upon data two years prior to the rate year, consisting of hospital-specific case-based

education amount determined pursuant to section 86-1.54(g) of this subpart;

(5) plus the value of forty-five percent of the indirect medical education expenses as determined pursuant to section 86-1.54(h)(1)(iv)-(v) of this subpart;

(6) plus the value of fifty-five percent of the indirect medical education expenses reflected in the hospital's peer group average inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart;

(i) For discharges on or after April 1, 1997 through March 31, 1999 and July 1, 1999 through March 31, 2000, the DRG case-based rates of payment shall be the sum of:

(1) an amount, determined pursuant to subdivision (c) of this section, excluding those costs for direct and indirect medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2) respectively, of this subpart;

(2) minus three and thirty-three hundredths percent of the amount determined in accordance with paragraph (1) of this subdivision to encourage improved productivity and efficiency;

(3) plus the value of direct medical education as determined pursuant to section 86-1.54(g) of this Subpart;

(4) minus three and thirty-three hundredths percent of the costs of hospital based physicians reflected in the direct medical education amount determined pursuant to section 86-1.54(g) of this subpart;

(5) plus the value of forty-five percent of the indirect medical education expenses as determined pursuant to section 86-1.54(h)(1)(iv)-(v) of this subpart;

(6) plus the value of fifty-five percent of the indirect medical education expenses reflected in the hospital's peer group average inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart;

(j) Effective July 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, 2000, rates of payment for inpatient acute care services shall be reduced by the Commissioner to encourage improved productivity and efficiency by a factor determined as follows:

(1) An aggregate reduction shall be calculated for each hospital based on: the result of eighty-nine million dollars and trended to the rate year on an annualized basis for each year, multiplied by the ratio of hospital-specific case based Medicaid patient days, in a base year two years prior to the rate year, consisting of hospital-specific case-based Medicaid patient days divided by the total of such patient days summed for all hospitals.

(2) The result of each hospital shall be allocated to exempt units within such hospital based on the ratio of hospital specific exempt unit Medicaid patient days to hospital specific total Medicaid patient days of which the result is divided by the hospital specific exempt unit Medicaid patient days to produce a unit of service reduction in the per diem rates of payment.

(3) Any amount not allocated to exempt units shall be divided by case based discharges (or for exempt hospitals by patient days) in the base year two years prior to the rate year, resulting in a per case (or for exempt hospitals a per diem) unit of service reduction in payment rates.

86-1.54 Development of DRG case-based rates of payment per discharge. (a) The hospital-specific average reimbursable inpatient operating cost per discharge shall be determined by dividing hospital-specific non-Medicare reimbursable operating costs determined pursuant to paragraph (1) of this subdivision by non-Medicare discharges determined pursuant to paragraph (2) of this subdivision and dividing this result by the hospital-specific case mix index determined pursuant to paragraph (3) of this subdivision.

(1) Hospital-specific non-Medicare reimbursable operating costs shall be the hospital's 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this Subpart including any adjustments made pursuant to section 86-1.52(a)(iii)(a)(iv), and (v) of this Subpart but excluding the following costs:

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) transfer costs as defined in subdivision (f) of this section;

(v) short-stay outlier costs as defined in subdivision (f) of this section; and

(vi) high-cost outlier costs as defined in subdivision (f) of this section.

(vii) For rates of payment for discharges occurring on or after April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, 2000 the reimbursable base year inpatient administrative and general costs of a general hospital shall include reported administrative and general data, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs. Excluding providers reimbursed on an initial budget basis, such administrative and general costs shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. This limitation shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the Commissioner for each general hospital. Reimbursable base year administrative and general costs, for purposes of this paragraph, shall mean those base year administrative and general costs remaining after application of all other efficiency standards,

to paragraph (a)(3) of this section. The group average wage and case mix adjusted operating cost per discharge shall be based on hospital-specific reimbursable operating costs which shall be calculated as follows:

(1) The following costs shall be subtracted from the sum of the hospital's allowable 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this subpart and any adjustments made pursuant to section 86-1.52 (a)(1)(iii)(a), (iv), and (v)(a).

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) direct GME costs as defined in subdivision (g) of this section; and

(v) hospital-specific operating costs as defined in subdivision (g) of this section.

(vi) For rates of payment for discharges occurring on or after April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, 2000 the reimbursable base year inpatient administrative and general costs of a general hospital shall include reported administrative and general data, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs. Excluding providers reimbursed on an initial budget basis, administrative and general costs shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. This limitation shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the Commissioner for each general hospital. Reimbursable base year administrative and general costs, for purposes of this paragraph shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines.

(2) The hospital-specific portion of the $40 million base enhancement specified in section 86-1.52(a)(1)(iii)(b) of this Subpart shall be added to the costs determined for each hospital in

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Development of Outlier Rates of Payment.

(a) Short Stay Outliers. Payments for short stay outlier days shall be made at a per diem calculated by multiplying the days of actual length of stay below the short stay threshold by the short stay per diem rates defined in this subdivision. The short stay per diem rate shall be determined by dividing the hospital's DRG case-based rate of payment determined pursuant to section 86-1.52(a)(1) by the hospital's group average arithmetic inlier LOS for the DRG and multiplying the result by the short stay adjustment factor of 150 percent. For rate periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, 2000, the short stay adjustment factor shall be 100 percent. In cases where the group average arithmetic inlier length of stay for the DRG is equal to one, the short stay adjustment factor shall not be applied. Budgeted capital costs determined pursuant to section 86-1.59 of this Subpart shall be added to the per diem.

(b) Long stay outliers. Payments for long stay outlier days shall be made at a per diem rate calculated by multiplying the days of the actual length of stay in excess of the long stay outlier threshold by 60 percent of the per diem obtained by dividing the group average DRG operating cost per discharge defined in section 86-1.54 (b) of this Subpart by the hospital's group average arithmetic inlier length of stay for the DRG. For rate periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, 2000, 50 percent of the per diem shall be used in the calculation. This result shall be multiplied by the percent for the group average reimbursable inpatient operating cost determined pursuant to section 86-1.53 of this Subpart. These payments shall include a health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(1) For the period April 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(2) For the period January 1, 1996 through March 31, 1997, a health care services allowance of 1.09 percent of the hospitals non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.614 percent for rate year 1994 and .637 percent of the rate year 1995 of [redacted] hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

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86-1.58 Trend Factor. (a) The commissioner shall establish trend factors for hospitals to project the effects of price movements on historical operating costs. Rates of payment excluding capital, as calculated pursuant to the provisions of section 86-1.52 of this Subpart, shall be trended to the applicable rate year by the trend factors developed in accordance with the provision of this section.

(b) The methodology for establishing the trend factors shall be developed by a panel of four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the commissioner.

(c) The methodology shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for non-supervisory employees. For 1996 through December 31, 1999, the commissioner shall apply the 1995 trend factor methodology.

(d) The commissioner shall implement one interim adjustment to the trend factors, based on recommendations of the panel, and one final adjustment to the trend factors. Such adjustment shall reflect the price movement in the labor and non labor components of the trend factor. At the same time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factor.

(e) Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors of final trend factors used for the January 1, 1995 to December 31, 1995 rate period for purposes of projecting allowable operating costs to subsequent rate periods.

(f) Trend factors used to project reimbursable operating costs to the rate period commencing April 1, 1996 through March 31, 1997, shall not be applied in the development of the rates of payment. This section shall not apply to trend factors or final trend factors used for the January 1, 1995 through December 31, 1995 or January 1, 1996 to March 31, 1996 rate period for purposes of projecting allowable operating costs to subsequent rates periods.

(g) Trend factors used to project reimbursable operating costs to rate periods commencing July 1, 1999 through March 31, 2000 shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

86-1.59 Capital expense reimbursement for DRG case based rates of payment. Capital expense shall not include capital expense allocated to exempt units and designated AIDS centers.

(a) The allowable costs of fixed capital (including but not limited to depreciation, rentals and interest on capital debt or, for hospitals financed pursuant to Article 28-B of the Public Health Law, amortization in lieu of depreciation, and interest and other approved expenses associated with both fixed capital and major movable equipment) and major movable equipment shall, with the exception noted in subdivisions (c), (g), (h), (i) and (j) of this section, be reimbursed based on budgeted data and shall be reconciled to total actual expense for the rate year and shall be determined and computed in accordance with the provisions of sections 86-1.23, 86-1-24, 86-1.29, 86-1.30 and 86-1.32 of this Subpart. In order for budgeted expenses to be reconciled to actual:

(1) Rates of payment for a general hospital shall be adjusted to reflect the dollar difference between budgeted capital related inpatient expenses included in the computation of rates of payment for a prior rate period and actual capital related inpatient expenses for the same prior rate period. For rates commencing April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, 2000, if a factor for the reconciliation of budgeted to actual capital related inpatient expenses for a prior year is included in the capital related inpatient expenses component of rates of payment, such component shall be reduced by the difference between the applicable reconciled capital related inpatient expenses for such prior year, and capital related inpatient expenses for such prior year calculated based on a determination of costs related to services provided to beneficiaries of the Title XVIII federal social security act (Medicare) based on the hospital's average capital related inpatient expenses computed on a per diem basis.

(2) This amount shall be adjusted to reflect increases or decreases in volume for the same rate period.

(3) Capital related inpatient expenses included in the computation of payment rates based on budget shall not be included in the computation of

transferred out patient days and which shall be reconciled to actual rate year days) and the non-exempt hospital's average budgeted capital cost per day calculated using total non-exempt budgeted days. Budgeted capital costs shall be reconciled to actual capital costs for the non-exempt hospital in the rate year after these data are available based upon the non-Medicare share of capital costs derived by subtracting Medicare capital costs from total capital costs. Medicare capital costs shall be determined based upon the hospital's average capital related inpatient per diem effective through March 31, 1999 and from July 1, 1999 through March 31, 2000. Total Medicare capital shall be these ancillary costs added to the routine portion of Medicare inpatient capital adjusted for secondary payors.

(3) Allocation to payments for transfer patients and short-stay patients. Budgeted capital costs shall be allocated to payments for transferred patients and short-stay patients based on estimated non-exempt unit non-Medicare days reconciled to actual rate year days.

(f) Payment for budgeted allocated capital costs.

(1) Capital per diems for exempt units and hospitals shall be calculated by dividing the allocated non-Medicare capital costs identified in paragraph (e)(1) of this section by the 1985 exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital approved capital expense.

(2) Capital payments for DRG case-based rates shall be determined by dividing the budgeted capital allocated to such rates by the hospital's most recently available annual non-Medicare, non-exempt unit discharges

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and actual rate year non-exempt unit or hospital-approved capital expense.

(3) Capital payments for transferred and short stay patients shall be the non-exempt hospital's average budgeted capital cost per day determined pursuant to paragraphs (2) and (3) of subdivision (e) of this section.

(g) Effective April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, 2000, the capital related inpatient expense component of the rate shall be based on the budgeted capital related inpatient expense applicable to the rate year decreased to reflect the percentage amount by which the budget for the applicable base year's capital related expense exceeded actual expense.

(h) Effective April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, 2000, rates of payment for inpatient acute care services associated with the capital related inpatient expense component and the capital cost per visit components shall be adjusted to exclude such expenses related to the following:

(i) 44% of major moveable equipment
(ii) staff housing.

(l) Adjustments to rates made pursuant to this section shall be made prospectively, and for rate periods commencing January 1, 1997 through March 31, 1999 and July 1, 1999 through March 31, 2000, may be made prospectively or retrospectively, based on the methodology for calculation of rates of payment for such prospective rate period.

(m) Hospitals may appeal the determination of allowable cumulative increases in case mix for the rate year pursuant to section 86-1.60 of this Subpart based on such factors as changes in hospital service delivery and referral patterns. An appeal pursuant to this section must be submitted within 90 days of receipt of notice of such determination and any modified rate certified pursuant to this subdivision shall be effective as of the date of the case mix adjustment.

(n) The appeal process shall be in accordance with section 86-1.17(c), (e) and (f) of this Subpart, provided, however, that documentation sufficient to support such appeal, including verifiable costs and statistics, must accompany every appeal. Letters of intent to appeal or appeal packages lacking such documentation shall not be accepted or considered to be an appeal.

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(iii) A bad debt and charity care allowance, a health care services allowance and a financially distressed allowance as determined pursuant to the provisions of section 86-1.65 of this Subpart.

(d) Rates of Payment for Acute Care Children's Hospitals. Hospital services provided to non-Medicare patients in acute care children's hospitals shall be reimbursed on a diagnosis-related group basis composed of:

(1) 1994 reimbursable operating costs computed on the basis of the hospital's reimbursable operating costs as defined in paragraph (a)(4) of this section and statistical data for the same period. The base year Medicare share of these costs will be removed in accordance with paragraph (a)(5) of this section. The non-Medicare hospital operating costs shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base to the rate year using total reimbursable non-Medicare costs and statistics of the hospital pursuant to section 86-1.64 of this Subpart. The DRG specific operating cost component shall be computed utilizing one-hundred percent hospital specific reimbursable costs with no adjustment for long stay or high cost outliers pursuant to section 86-1.54(f)(1) and (3) of this Subpart.

(2) The acute cost component computed on the basis of budgeted capital costs allocated to the inpatient portion of the hospital pursuant to the provisions of section 86-1.59 of this Subpart, divided by the budgeted discharges and shall be reconciled to total actual expenses and discharges;

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospitals' non-Medicare reimbursement inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) Discrete long stay and high cost outlier rates of payment shall not be paid.

(6) For rates of payment for the period April 1, 1996 through July 31, 1996, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education for Acute Care Children's Hospitals as determined pursuant to this paragraph shall be reduced by 5%, for the period August 1, 1996 through March 31, 1997 shall be reduced by 2.5% and for the period April 1, 1997 through March 31, 1999 and July 1, 1999 through March 31, 2000, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, shall be reduced by 3.33% to encourage improved productivity and efficiency.